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UTAH RECOVERY ASSISTANCE PROGRAM EVALUATION REPORT

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SCOPE

In February of 2019**,** the Department of Commerce Division of Occupational and Professional Licensing (DOPL) issued a Request for Proposal to evaluate the Utah Recovery Assistance Program (URAP). The growing trend of substance-related complaints against licensees, which more than doubled from 2013 to 2017, has resulted in a focus on the need to ensure that URAP is utilizing best practices, meets the guidelines of national standards, and provides Utah professionals with the support and monitoring necessary to increase the likelihood of recovery while simultaneously embracing DOPL's mission to protect the public and enhance commerce. An Evaluation Report and a Recommendation Report have been solicited. The following is the Evaluation Report. The Recommendation Report will be submitted to DOPL at a later date.

The purpose of this Evaluation Report is to summarize the findings of a comprehensive review and evaluation of URAP. DOPL identified many components to be included in this review, and we have identified many more. These components have been reviewed and compared to the best practice recommendations established by the Federation of State Physician Health Programs (FSPHP). It is vital to understand the challenges of operating a successful Professional Health Program and/or Physician Health Program (PHP) within this context. These guidelines reflect the consensus of existing PHPs, and also reflect years of experience and adaptation. They are considered the gold standard for PHPs.

METHODOLOGY

This Evaluation consisted of several approaches. Hundreds of pages of documents provided by or solicited from DOPL and URAP were examined. This included forms, policies and procedures,[1] mission statements, strategic plans, statutes, previously compiled comments from stakeholders, training manuals, previous audits, participant satisfaction surveys, and various statistics and referral data. We conducted both individual and/or group interviews with DOPL employees, the Director of URAP, URAP Committee members, Bureau Managers, Compliance Specialists, the Management Analyst, two Utah Assistant Attorney Generals, the Operations Manager, the Compliance Manager, the Chief Investigator**,** and Investigation Supervisors. Formal surveys were conducted of DOPL Board members from all professions, 11 DOPL employees**,** and 8 URAP Committee members (three from the Physician Committee, four from the Nursing Committee**,** and one from the Pharmacy Committee). We reviewed participant records and evaluated the scope of data collection. We observed two URAP Nurse Committee meetings, one Physician Committee meeting, one Pharmacy Committee meeting and one Compliance Interview. We reached out to four Utah professional organizations: the Utah Medical Association, the Utah Nurses Association, the Utah Pharmacy Association**,** and the Utah

[1] URAP's Policies and Procedures were unknown to DOPL and thus DOPL does not consider them to be official.

Dental Association. Dr. Lundberg attended the FSPHP conference and spoke with their current president, the president-elect**,** and many others.

Important policy statements and articles were also reviewed. This included**,** but is not limited to**,** the 2005 FSPHP Physician Health Program Guidelines, the 2008 American Medical Association's Official Statement on Physician Health Programs, the 2011 Federation of State Medical Boards (FSMB) Policy on Physician Impairment, the 2016 FSPHP Performance Enhancement Review (PER) Guidelines, the 2016 American Medical Society Physician Health Programs Act, the 2016 American Medical Association's Resolution on Physician Health and Wellness, the 2018 FSMB Physician Wellness and Burnout Report and Recommendations of the Workgroup on Physician Wellness and Burnout, and several policy statements of the American Society of Addiction Medicine addressing Physicians and Other Licensed Health Care Professionals with Addictive Illness.

Articles read included**,** but were not limited to, *Five Year Outcomes in a Cohort Study of Physicians Treated for Substance Use Disorders in the United States* published in the British Medical Journal in 2008; *How are Addicted Physicians Treated? A National Survey of Physician Health Programs* published in the Journal of Substance Abuse Treatment in 2009; and *Physician Impairment and Rehabilitation: Reintegration into Medical Practice While Ensuring Patient Safety: A position paper from the American College of Physicians*, published in the Annals of Internal Medicine in 2019.

ADHERENCE TO BEST PRACTICE GUIDELINES

As indicated above, many documents were utilized in identifying the salient best practices to be reviewed in this Evaluation. The 2005 FSPHP Physician Health Program Guidelines were central among these. FSPHP has updated their guidelines, however, as of the writing of this Evaluation, they have not yet been made available to the public or to FSPHP members. We encourage DOPL and URAP to become familiar with the guidelines once published and adapt the recommendations accordingly. In addition to the FSPH guidelines, we also utilized many of the recommendations from FSPHP's 2016 Performance Enhancement Review Guidelines and the 2011 Policy on Physician Impairment issued by the FSMB. We then consulted with DOPL and identified the following to be reviewed:

Structure and Administrative Functions

Organization Structure
Safe Harbor
Expertise of Staff
Conflict of Interest
Education and Outreach

Positive Relations with Licensing Authority and Professional Organizations

Data and Documentation

Data Collection
Privacy, Confidentiality and Storage of Records
Documentation and Thorough Record Keeping

Procedural Elements

Elements of the Monitoring Agreement
Intake and Assessment
Length of Monitoring and Frequency of Contact
Toxicology Testing and Evaluation
Response to Relapses
Response to Relapse Behaviors
Adherence to Treatment Frequency Recommendations
Processes for Dispute
Timely Response to Participant**s** Requests for Intervention and Assistance
Monitoring and Notification to Disciplinary Authority

Each section will begin with a statement of best practices in bold, as identified by FSPHP, and our findings will follow.

Structure and Administrative Functions

Organization Structure

PHPs must have the expertise and resources to completely manage all areas in which they offer services.

There are a variety of administrative and organizational structures employed by PHPs. Regardless, PHPs should always consist of clinical staff with an expertise in addiction as well as a physician who serves as a Medical Director (though not necessarily as the Director of the program). The number of staff employed depends upon the size of the state, the number of licensees served and their professions, and the types of disorders addressed. Some states have a small staff consisting of three to four individuals, and others employ numerous full time staff. Some states have a full time Medical Director, and others contract with this person on a part-time basis. The role of the clinical staff is broad. They handle all calls from participants and referents, as well as referrals from professional Boards. They interview the potential participant and make the appropriate referral for an assessment. They monitor progress and

compliance and respond immediately to problems or concerns, providing earned advocacy when appropriate. Most PHPs case manage and monitor participants on an individual basis. Thus there are no committee meetings, nor are there voluntary committee members who have no expertise in addiction. Some PHPs have clerical staff who track compliance; however, these individuals typically have no contact with the participant. In addition to these functions, staff of PHPs also provides wellness education throughout their state, spend time and energy educating and liaising with professional organizations, professional boards (including providing monthly or quarterly updates on board-mandated participants), hospital staff and administrators, and the public. Most PHPs have an executive or oversight committee to which they are accountable for best practices and quality assurance. Some states also use such committees as consultants for handling complex situations related to monitoring.

Obviously the structure of URAP is very different than described above. URAP employs a part-time Director, assigns Compliance Specialists to monitor compliance and manage documentation, and utilizes advisory committees consisting of volunteers. There are numerous deficiencies with this structure. First, there is only one individual, the URAP Director, who has an expertise in addiction. Clinical decisions are being made by committee members and, at times, Compliance Specialists; and often these decisions and duties fall outside of their scope of expertise. Second, there is no oversight of the Program. The URAP Director reports directly to DOPL's Division Director, and thus there is no clinical accountability built into the structure of URAP. Third, URAP does not employ enough clinical staff to effectively carry out the functions of a PHP. Fourth, as a result, URAP's structure appears inconsistent with DOPL's Mission Statement to administer programs and applications efficiently.

The statute and rules governing URAP's organizational structure are fairly consistent with the actual practice authorized by Utah Code Ann. 58-1-404. There are some exceptions to this. For example, 58-1-404-(2)(b)(i) indicates there must be at least three licensees from the same or similar occupation or profession as the participant. Because URAP accepts all eligible licensees, this becomes a challenge and is simply not feasible. While more can be said about the statutes, the existing organization structure of URAP is simply not consistent with a PHP, and thus the Recommendation Report will be proposing extensive statutory changes.

Safe Harbor

PHP participants are granted full confidentiality and their treatment is not disclosed to the licensing author if they maintain compliance and successfully complete the PHP.

By definition, safe harbor refers to participants being given anonymity and confidentiality while participating in a PHP. This includes remaining anonymous and confidential from the public as well as from the regulatory licensing agency, as long as the individual is compliant. This tenet is a cornerstone of PHPs as it is necessary to allow individuals in need of help to come forward without fear of recrimination and embarrassment. Assuming that participants have been appropriately screened, that monitoring is consistent with best practice guidelines, and that

there is a positive and trusted relationship between the PHP and the licensing authority (including the relevant professional boards), adhering to this practice increases the likelihood of individuals voluntarily entering the PHP before potential impairment manifests**.** Thus, this practice ultimately provides increased protection of the public.

Whether one enters URAP voluntarily or whether they are provided with the option of participating in URAP following professional misconduct, all participants are screened by DOPL's Investigations Unit. If that individual meets criteria for participation in URAP, Investigations screens the case with the Bureau Manager overseeing the profession and once he or she approves the referral, the Attorney General's office drafts the Diversion Agreement. Thus, three different offices within or associated with DOPL are aware of the individual's identity. While this is not an unusual practice for individuals who are referred through Investigations or by a professional board, it is not consistent with best practices for those individuals who are not mandated to participate in the PHP. For these individuals, who are already feeling vulnerable, an interview with Investigations will likely be perceived as an intimidating process, and it may ultimately serve as a deterrent to coming forward.

Once individuals are participating in a PHP, safe harbor should only exist for individuals who are not mandated to participate if the participants are compliant or the noncompliance can be managed without fear of harm to the public, as will be further explained below. Regarding individuals who are referred by their professional board or regulatory agency, most PHPs provide monthly or quarterly updates to the respective boards regardless of compliance. Sometimes this includes the participants' names, and sometimes these reports are anonymous. URAP does not provide any updates to the boards.

It should be recognized that while changes can be implemented to increase confidentiality and anonymity, the *perception* of safe harbor remains at issue. Prospective non-mandated participants may be reluctant to participate in a PHP if it falls under the umbrella of the state licensing authority for fear that anonymity and confidentiality is tenuous, despite efforts to reassure otherwise. Nonetheless, more recently, states have learned that safe harbor is never a guarantee. Some PHPs are now facing legislation requiring them to provide the names of non-mandated PHP participants to the licensing authority, regardless of compliance. Politics are ever fluctuating and, as we are learning, can have profound effects on issues of safe harbor. Ironically, a PHP that exists within a licensing authority may be more resistant to legislative changes since their influence in state matters affecting licensure is typically quite robust.

Expertise of Staff

In order to effectively manage individuals with substance use disorders, the PHP must be staffed with individuals who have the appropriate knowledge, skills, and resources.

URAP's Committee members have been extremely dedicated to helping individuals who struggle with substance use disorders. While some of these individuals have worked with

individuals struggling with addictions, few excepting the Director have any expertise in the treatment and management of substance use disorders. In addition, they receive no training for their role, and best practice standards and URAP policies are not disseminated.

As a result and not surprisingly, during the observations of the two URAP Nursing Committees**,** the URAP Pharmacy Committee and the URAP Physician Committee, there was a wide range of skill level demonstrated. Some Committee members were particularly deft in exploring and addressing substance use and recovery, while others were not.

For example, paternalistic comments made in an admonishing style were sometimes observed. In response to a participant's relapse, one Committee member stated, "I'm really disappointed." Another added, "You've really been such a good girl for a long time." Such statements convey judgment, do not facilitate abstinence, increase shame, and are not consistent with best practices.

There were a total of three participants who had recently relapsed and who were present at one of the four Committee meetings observed. In all cases, there was little concern expressed for the well-being of these individuals and little time spent exploring the factors that precipitated the relapse. Furthermore, there was no request to stop practicing, no request for a reevaluation**,** and, in two instances, no request to provide a relapse prevention plan.

During one Committee meeting, a participant was encouraged to form a Professionals in Recovery (PIR) meeting so she and other URAP participants could attend (there is no PIR available in this area of Utah). While this would be an inappropriate request of any participant, this particular individual had only been participating in URAP for nine months and had had two recent relapses within the two months prior to the Committee meeting. Such a request ignores and abuses the power differential that inherently exists between URAP Committee members and the participant. Furthermore, the request was clearly counterproductive for a participant who is struggling to maintain her abstinence. Instead, the focus should be on reducing her stressors and managing her recovery.

A lack of expertise was also exhibited in the practice of allowing participants to be prescribed potentially addictive medication. Adderall, clonazepam, and tramadol were each being prescribed to three separate participants. When asked about URAP's policies regarding controlled substances, URAP's Director stated that, with the exception of requiring the participant to provide a copy of the prescription to the Compliance Specialist, URAP does not preclude this practice. He stated, "If a competent practitioner thinks they need a controlled substance, we do not want to interfere with the professional opinion." Rarely is the use of a benzodiazepine or tramadol accepted as a best practice in the treatment of an individual who has a substance use disorder. While best practices indicate that a prescription for Adderall or similar medication may be indicated for some individuals with substance use disorders and co-occurring Attention-Deficit Hyperactivity Disorder, this is only allowed after a thorough evaluation by a psychiatrist.

Finally, some events occurred either during the observation of the Committee meetings or during the review period that speak to issues of professionalism and warrant mentioning. They are as follows:

1. Many of DOPL staff noted they had observed URAP's Director sleeping during meetings. This did not occur during our observations; however, following one of the Committee meetings in May of 2019, a participant wrote the following to the Compliance Specialist: "I wanted to thank you and the rest of the women for your time and attention in our meeting today. I also would like to point out that Charles Walton fell asleep for half of it. I found this very disrespectful. If he's going to be leading the group and making decisions in my case I would appreciate his attention and respect of being awake to listen."
2. The cell phone of URAP's Director rang during three of the five Committee meetings observed, although in all cases it was not answered.
3. One participant wrote to express concerns about a violation of confidentiality that occurred during a PIR meeting by a member. This concern was appropriately conveyed to the PIR leader. During a Committee meeting, another participant indicated that in the most recent PIR meeting, the PIR leader informed the group that a complaint had been made. The URAP Director insisted on knowing which URAP participant had made the complaint. The Compliance Specialist reminded him that a participant's name could not, and should not, be shared when another participant is present.
4. URAP's Director was required to recuse himself during the meeting with one participant due to a conflict of interest. Upon returning to the room following the participant's meeting with the Committee, the Director commented on the strength of the participant's cologne, and indicated, "I wonder what he's trying to hide," adding that strong cologne is sometimes used to "cover up methamphetamine use".

Despite the above concerns, there were many occasions when the Committees engaged in creative problem solving and praised participants when they were doing well. Additionally, it was apparent that Committee members care deeply about the well-being of the participants**,** and this was frequently expressed. This includes the Director whose passion and dedication to helping individuals with substance use disorders was frequently obvious.

Conflict of Interest

The PHP has, and consistently follows, a clear policy regarding avoiding and addressing financial, as well as other, conflicts of interest.

No written policy exists. URAP staff and Committee members are not required to sign an acknowledgment that they are not in violation of such a policy.

Education and Outreach

PHPs promote physician and professional wellness and the treatment of all health conditions including substance use disorders and other addictions, mental and behavioral disorders, and physical illness.

FSPHP has identified a number of different ways for PHPs to promote wellness and the treatment of substance use disorders. This includes education targeted at students, professional associations, hospitals, medical groups**,** and legislators. In other words, PHPs should be leaders in the field providing education, guiding policy**,** and decreasing stigma. Education and outreach should also include informing individuals of the existence of the state's PHP**,** and fostering relationships with colleagues, professional organizations, stake holders**,** and the community.

The Director of URAP indicates that while he used to provide education regarding URAP and professional wellness, he has not done so in quite some time. There are two general consequences as a result. One is that important information regarding wellness is not being provided to vulnerable professions. The other is that knowledge of the existence of URAP is limited.

In order to assess the various professions' knowledge of URAP, we surveyed the board members of all DOPL licensed professions regarding their knowledge of URAP and received 80 responses (see Attachment A). While it was not surprising to find that professions with few substance-related referrals were unaware of the existence of URAP, it was surprising to find that 57% of those who returned surveys reported no knowledge of URAP at all. This included a member of the Physician Board and the Nursing Board, the two professions that account for most of URAP's participants and led to the creation of a URAP Physician Committee and Nursing Committee. Additionally, only 33% of those surveyed indicated a favorable opinion of the program; and 27% of those who returned surveys indicated that lack of awareness or knowledge about the existence of URAP was the biggest barrier to utilizing URAP.

At the time of writing, there are 65 active participants in URAP from various professions (see Attachment B). Since URAP does not distinguish between those participants who are not mandated to participate and those who were referred by DOPL, it is not clear how many of these individuals had prior knowledge of URAP. One would expect that most of URAP's participants would be individuals from the nursing profession, and this is consistent with the information we have (35 participants). However, the field of pharmacy appears to be highly underrepresented (only 2 participants).

Finally, the website, a tool which by definition should educate the public about URAP, has previously provided little information about the purpose, philosophy, and procedures of URAP. With that in mind, DOPL staff have expressed a commitment to update the site upon completion of this consultation and review process.

Positive Relationship with the State Licensing Authority and Professional Organizations

To operate effectively, programs must develop and maintain a positive relationship with the state licensing authority and professional organizations.

Relationship with DOPL

As our Evaluation shows, there is a great deal of distrust between DOPL staff and URAP. The nature of the distrust generally falls into two categories - transparency and consistency. More specifically, URAP has been perceived as protecting participants from referral to the professional probationary boards despite multiple severe relapses and, in some cases, criminal behavior. URAP has also been perceived as applying inconsistent standards to various professionals participating in the program. Despite the marked lack of trust, DOPL staff sees the existence of a PHP as a valuable resource and there is remarkable support and optimism for improving the program.

In addition to the lack of trust between DOPL and URAP, there was a noted discrepancy between the way the DOPL staff and URAP Committee members perceive URAP's expertise (Attachment C). As indicated above, most of URAP's Committee members – like DOPL staff - have little to no expertise in the area of addiction, and many of them indicated they were not aware that best practice guidelines even existed. This discrepancy between the two organizations is not meant to imply one is right and one is wrong; it simply underscores that DOPL staff appear to have little faith URAP is performing competently.

Relationship with Professional Organizations

As for URAP's relationships with professional organizations, while it is not necessarily negative, it does seem to be nonexistent. To explore this, we reached out to the Utah Medical Association, the Utah Nurses Association, the Utah Pharmacy Association**,** and the Utah Dental Association and asked them about their relationship with URAP and their knowledge of the program.

The president of the Utah Medical Association, Dr. Howard Weeks, as well as the CEO, Michelle McOmber, both indicated a general awareness of URAP, but stated they had little information as to how the program functions or how it is structured. Ms. McOmber stated:

I believe it's an important program and would like to see it restructured so I could feel that it's serving physicians well.

Ms. McOmber also added that she was under the impression there was an agreement between the Utah Medical Association (UMA) and DOPL that a portion of physician licensing fees, in

addition to fines levied for those physicians who had complaints that were founded by Investigations but did not approach the threshold for probation, would go toward funding URAP. It was her belief this is not occurring since she receives a call annually to discuss options to use this money for physician education. Upon further investigation of this matter, it appears there is a fund called the Physicians Education Fund. It is indeed funded from fines assessed to physicians when they violate various unlawful or unprofessional licensing law provisions. However, it is not intended to provide any funding for URAP.

Diane Forster-Burke from the Utah Nursing Association indicated the following:

Nursing professionals do not seem to be familiar with the "Diversion Program" and how one gets involved with it as a "probationer" or nurse with an addiction problem. I suspect that other nurses may not understand how to recommend anyone to call the UARP (sic).

Mr. Adam Jones from the Utah Pharmacy Association indicated:

We brought this subject up in our Board Meeting this morning. Most in the room were not familiar with the program and so were not able to provide any feedback on the program. I had one person that mentioned that in a previous audit of the program they were aware that changes needed to happen and were glad to see that the program is getting reviewed.

Val Radmall from the Utah Dental Association indicated:

We seem somewhat removed from the processes of URAP. It might be useful to hear what has been done by URAP, before discussing changes. We do not know specifics on this.

In sum, there does not appear to be a relationship between URAP and these professions, despite URAP being comprised of Committees specifically serving three of them. Furthermore, none of these professional organizations had familiarity with how URAP can serve their professions. Finally, there appears to be a misunderstanding between DOPL and UMA regarding the Physicians Education Fund.

Data and Documentation

Data Collection

Information routinely collected should include standardized information from intake, evaluation, treatment and monitoring. At minimum, information gathered includes referral source, participant demographics, diagnoses, substance of choice, treatment (type and duration), outline of the clinical course (disease exacerbations and detailed relapse information), health status and compliance status at time of monitoring completion, i.e.,

successful completion, transfer, board referral, enrolment in continued voluntary monitoring, etc.

As both DOPL and URAP are aware, in October of 2015 a Compliance Program Review found that URAP had no formal means of consistently keeping records on the progress of their participants. This is not to say the URAP was unaware of issues of relapse and compliance, but the data and information was not systematically or consistently documented. Following this Review, URAP Compliance Specialists entered all participants' names into Spectrum, and indicated that all of them had successfully graduated. This included individuals who had had an initial meeting with URAP but then declined to participate, as well as participants who in actuality were referred to probation. Furthermore, the data retroactively added did not include information on treatment and relapse. After a change in staff and another Compliance Program Review in November of 2016, URAP's Compliance Specialists began accurately and more thoroughly entering data into Spectrum. Under the directive of the Director of URAP, however, this includes those individuals who met with URAP but declined to participate. The information in Spectrum does not distinguish between those who are actively participating and those who are not, or in fact, never were.

Additionally, URAP is not consistently entering data on ethnicity, marital status, or work status within the provided fields. While this information can sometimes be found within the notes section, information is inconsistent and difficult to track. Drug of choice is entered, but fields regarding route of administration and dates of use are left blank. When a participant begins the program, means of entry is not included in the initial data entry into Spectrum, so it is unclear whether a participant was self-referred, referred by their board, or sent through Investigations. Similarly, when a participant leaves URAP, there is no distinction between those who have successfully completed the Program, and those who were either referred to probation or opted to surrender their license. For some participants, it is possible to find this information within Spectrum, but only by reading through the case notes. Without complete data for each participant, it is difficult to assess the success of URAP. Nevertheless, the improvement in the data collection is commendable.

Another item of note is that submission of reports is not always entered into Spectrum in a way that reflects whether reports are actually turned in or not. For example, in the dashboard calendar of many participants, quarterly reports are scheduled, and the majority are labeled as missing. However, in looking at the notes sections of those participants, Compliance Specialists will often document that reports have been submitted, but at times it is not clear whether this includes all required reports, particularly when phrasing such as "some reports" is utilized.

Privacy, Confidentiality and Storage of Records

The PHP has, and consistently follows, a distinct policy regarding privacy and confidentiality of its records and any related communication, including privacy breaches. Documents should

be maintained for a minimum of 10 years after case closure unless otherwise required by law; and they should be stored under double lock.

URAP's Policies and Procedures indicate:

Individual confidential files shall be created and maintained on each Prospective Diversionee and stored in secure cabinets which are accessible only to the Manager or Coordinators of URAP or their designees.

Despite this, all hard copies of participant records are kept in a public area in an unlocked file cabinet, and thus the policy is not adhered to.

There appears to be no policy regarding the confidentiality of URAP's communications. Much of the communication occurs with the Compliance Specialist via Spectrum email. Records of URAP participants are kept separately in the database and thus no other staff can access the information. However, when URAP staff receive notice of a relapse, via an alert from Spectrum, the Compliance Specialist reaches out to the participant by phone. All of the Compliance Specialists assigned to URAP work in a cubicle within an open office plan. As a result, the most sensitive telephone communications are not private.

Finally, as for the storage of records, all electronic records are maintained indefinitely and hard copies are maintained for a period of 10 years. However, there is no policy in place stating this.

Documentation and Thorough Record Keeping

The PHP documents all participants' interactions with the PHP staff into a written or electronic record, in order to track his/her course.

As previously mentioned in the review, in October of 2015, a Compliance Program Review found that participant interactions with URAP staff were not being documented electronically or within a written record. A subsequent Review in November of 2016 found an improvement, but still a lack of consistency in documentation. Since then, there has been a concerted effort in this area including the development of policies and procedures for entering data into Spectrum. This includes a thorough training manual for Compliance Specialists. A review of the records of the individuals who began participating in URAP following the 2016 Review reveals that documentation of interactions appears consistent and comprehensive.

Procedural Elements

Elements of the Monitoring Agreement

Basic contractual components between state PHPs and participants, whether voluntary or mandated, should include the following components:

1. **Agreement of good faith participation.**
2. **Agreement for abstinence and the requirement to immediately report any use of alcohol or mood altering chemicals.**
3. **Agreement to not prescribe scheduled drugs for family members and a strong recommendation to refrain from treating their family members.**
4. **Agreement to not manage one's own medical care.**
5. **Agreement to attend self-help groups such as AA/NA. Those with strong objections should be responsible for providing recovery focused alternative with appropriate availability and intensity.**
6. **Agreement to attend a facilitated weekly support group for recovering professionals or approved alternative when not available.**
7. **Agreement to maintain consent for ongoing communication with an approved workplace monitor/contact.**
8. **Agreement to abide by any specified workplace restrictions.**
9. **Agreement to maintain consent for the physician health program to speak with the participant's family/SO as needed.**
10. **Agreement to submit to biological specimen monitoring without question.**
11. **As statement of the confidentiality provided and the limitations of the same.**
12. **Informed consent and the limitations thereof.**
13. **A statement of individuals who must agree in writing to contractual monitoring changes if applicable.**
14. **Agreement that monitoring will be transferred to the appropriate state PHP or Licensure Board if the participant moves.**
15. **Agreement to faithfully follow up with designated treatment providers and/or others designated in the participant's contract.**
16. **Agreement to the release of information to the state licensure authority in the case of indefeasible non-compliance.**
17. **Optional contract components may include but are not limited to, notification of the state PHP for:**
    a. **Travel outside monitoring area**
    b. **Change of address**
    c. **Change of employment**
    d. **Malpractice claims**
    e. **Arrests**
    f. **Work site and performance difficulties**

URAP's current Diversion Agreement is quite comprehensive, and covers a majority of the topics listed above. There are three items listed that are inferred within the Diversion Agreement, but not specifically indicated. The first item has to do with self-reporting of relapse (item #2). Specific information regarding the requirement to self-report a relapse is not directly stated within the Agreement, but one can infer the requirement based on additional forms given to participants, such as the URAP Self Report for Relapse. Second, regarding item #4,

URAP's Diversion Agreement states that "Licensee shall consult with only one physician and fill prescriptions at only one pharmacy", which implies that the licensee should not be managing his or her own care, but this is not directly indicated within the Agreement. The third item of note is #13. While the agreement states that the Division may waive requirements imposed upon a licensee, it does not state who must agree in writing should any amendments to the original contract occur.

Finally, there are no mentions of optional components, specifically travel outside the monitoring area, malpractice claims, or work site and performance difficulties within the current Agreement. Again, it could be inferred that these are required in some form. For example, based on examining the notes documented in Spectrum, it is clear that participants must notify their Compliance Specialist of travel plans and monitoring interruptions. Additionally, required monthly employer reports, if completed accurately, could also serve as notification of any malpractice issues and/or work site and performance difficulties.

Intake and Assessment

PHPs should have mechanisms in place to accept and follow-up on reports of professionals with potentially impairing health conditions. Intervention or initial contact is made for the purpose of determining the appropriate evaluation or referral. Healthcare and other licensed professionals with addictive illnesses should receive a comprehensive multidisciplinary evaluation and any indicated treatment by PHP-approved Addiction Treatment Programs (ATPs) with experience and expertise in working with this population.

Typically an individual contacts URAP via a telephone call or an email. The Director responds in turn, sometimes through email and sometime with a telephone call. The Director provides information about URAP, and then refers the individual to the Investigations Unit (as described above) and also refers them for an assessment. The individual is then scheduled to meet with the Committee most closely associated with the profession of the licensee which, depending upon the profession, may take place within a month or within three months. When the individual appears before the Committee, he or she is questioned regarding the circumstances that led to the request to enter URAP. Following the Committee meeting, the individual can choose to sign the Diversion Agreement. The Compliance Specialist then goes over the details of the Agreement, including explaining the various forms required, and obtains the necessary signatures.

It appears there is a great deal of inconsistency in this process and there are no policies and procedures in place to provide guidance or to outline the minimum information that should be provided or obtained from the potential participant. As indicated above, some individuals receive a phone call, some an email response. Additionally, URAP Compliance Staff indicate individuals are sometimes given a choice of assessment agencies, and sometimes are directed to a specific entity for an evaluation.

While URAP's policies and procedures indicate the assessment agency must be approved by PHP, the agencies that meet approval for the assessment of physicians do not meet FSPHPs standards which include having a multi-disciplinary team of individuals with specific expertise in distinct but interrelated specialties perform the evaluation, the collection of collateral information, investigating the workplace environment and associated risks, completing psychological and neurocognitive testing and performing intricate drug screen testing tailored to the specific individual. It should be noted that there are few such agencies and many PHPs find themselves in a position of providing the potential participant a minimum of three choices, all of which may be out of state. These assessments can be quite expensive, ranging anywhere from approximately $1000 to $3500, which is likely much less than the cost of assessments by the agencies to which URAP typically refers. Assessments by an ATP are typically covered by insurance for those who are employed. Despite the expense, the resulting assessment and recommendations lead to confidence in the type of treatment and monitoring that is necessary, which in turn increases the likelihood of the professional's success. PHPs should also develop criteria for which to approve agencies that provide assessments of other professions.

PHPs typically have a mechanism in place to immediately respond to requests with a scheduled phone call or an in-person visit, often with the Director. During this contact, a great deal of information is solicited. While these initial contacts are not considered assessments, they are intended to obtain enough information to make the appropriate referral and determine whether the individual should be reported to the board.

There are two other issues of note with the intake and assessment process. Most PHPs receive frequent phone calls from hospital administrators, concerned family members and others who express a concern about an individual; and PHPs have a mechanism in place as to how to address these. This appears to rarely happen at URAP and may be due to a lack of public knowledge about the Program. Finally, PHPs have different exclusion criteria for their programs. URAP appears to follow the procedures they have established which, as previously described, include a screening of eligibility by the Investigations Unit regardless of the nature of the referral. Suggestions regarding exclusion criteria will be further discussed in the Recommendation Report.

Length of Monitoring and Frequency of Contact

The minimum period of monitoring for substance use disorders is 5 years. The PHP consistently follows existing policies regarding minimum allowable frequency of contact the participant may have with PHP staff. The policy clearly delineates contingencies that are activated when the participant does not comply with these standards and demonstrates consistent and punctual implementation of these contingencies.

URAP's policy is much less specific and instead indicates:

Length of probation (sic) is determined on an individual basis by the Advisory Committee, but in most instances will be for a minimum of five years.

The policy, however, does not outline what procedures will be used to determine the length "of probation". That said, the length of monitoring appears to typically be 5 years. There have been exceptions made to this, including reducing the length of participation to 2 years after an assessment revealed no substance use disorder. While this appears to be a reasonable decision (although perhaps this individual should not be monitored at all), a written policy should outline the possible exceptions to full length monitoring for purposes of consistency, accountability and transparency. For example, PHP best practices suggest monitoring an individual diagnosed with a mild substance use disorder for one to two years, and monitoring an individual who has been diagnosed with a moderate to severe substance use disorder for no less than five years. Many PHPs have policies in place that outline the circumstances that would warrant extending monitoring beyond five years and most would do so if there was any type of relapse occurring during the fourth or fifth year of monitoring.

During the observations of the URAP Committee meetings, several participants requested early graduation. Some of these participants were told URAP did not typically grant early graduation, and some were told that they grant early graduation under certain conditions. When no participants were present, the URAP Director reported he is reluctant to inform individuals they can request early graduation because it may lead to an increase in the numbers of such requests. While unusual, there may be a reason for an exception to a 5 year length of monitoring, but because no policy exists, it is unclear as to how URAP would evaluate the participant's request. Additionally, URAP should be transparent with participants so as they know what to expect throughout the course of their monitoring in the program.

The policy regarding frequency of contact is also vague. The policy indicates:

Frequency of Committee interviews is determined on an individual basis by the Advisory Committee, but is generally monthly for the first quarter and then quarterly. Other circumstances, such as a lapse, may indicate the need for more frequent meetings and, thus, the frequency of meetings is dynamic, dependent on individual circumstances.

Once again, it is not clear how these decisions are made. It is similarly unclear and difficult to imagine a circumstance in which a participant relapses and is not automatically required to meet more frequently with the Committee. There are no written policies regarding minimum allowable frequency of contact the participant has with URAP staff, nor for the contingencies activated when the participant does not comply. The URAP Agreement states the individual must initially meet with URAP monthly and this can be extended to quarterly should consistent compliance be demonstrated. Most PHPs have fairly frequent contact with their participants that occurs with a case manager either in person, via the telephone, or through telecommunication.

Fees for participation throughout the monitoring process vary greatly across PHPs. Those programs that do not have monthly fees, like URAP, typically have funding from multiple sources or exist within the regulatory authority. Like URAP, other PHPs require participants to bear the cost of any outside assessment, treatment and toxicology tests. This will be further discussed in the Recommendation Report.

Toxicology Testing and Evaluation

PHPs should have a distinct policy or procedure for random toxicology testing frequency, collection and internal evaluation of the laboratory results, and consistently follows this policy or procedure. The purpose is to monitor and document participants' abstinence from substances of abuse.

URAP has no written policy for random toxicology testing frequency, collection and internal evaluation of laboratory results. The unwritten policy is that all individuals are tested 14 times per year, for the entire period of their participation in URAP. This is much less than most PHP programs, which typically require random toxicology testing weekly within the first year. There is also no policy in place to determine the type of testing that should be conducted given the drug of choice.

Also unwritten is that frequency of testing increases when patients have relapsed, have a diluted toxicology test or an abnormal toxicology test. However, there appears to be a lack of consistency as to how decisions to increase testing are made, and under what circumstances.

There is no similar response of increasing testing when participants are either demonstrating worrisome relapse behaviors or when participants are known to be encountering high-risk situations. Such policies, if in place, may be successful in preventing a relapse from occurring.

Participants, by contract, are required to enroll in Spectrum where they receive notice of testing and where results of testing are documented. Compliance Specialists receive immediate notification when testing results are positive, diluted or abnormal. When results are difficult to interpret, Compliance Specialists contact the Medical Director of Spectrum for consultation and typically receive an immediate response.

It is standard practice that participants absorb the costs of their toxicology testing. Depending upon the type of testing, this can range in price from approximately $65 to $390.

Responses to Relapse

The PHP should consistently demonstrate an ability to quickly respond to incidents in which a participant has a laboratory finding suggestive of chemical relapse. The PHP consistently follows an algorithmic relapse protocol to conduct tissue or bodily fluid testing, document

any relapse and guide the appropriate treatment response to each chemical relapse, and thus, prevent exposure of the public to medical care by a provider who may be potentially impaired.

As indicated above, Compliance Specialists receive notification when a laboratory finding is suggestive of a substance related relapse. When this occurs the Compliance Specialist phones the participant, informs the individual of the relapse, and typically asks the participant to provide an explanation. Some Compliance Specialists ask for a written explanation, some do not. Because the Compliance Specialists have no expertise in the field of addiction, there is no assessment of the participant's continued vulnerability to relapse. Additionally, there is no request to withdraw from practice, and no recommendations for further assessment or treatment. In all cases, the participant is required to attend the next URAP Committee Meeting. As previously indicated in this Evaluation, there are three URAP Committees. The Nursing Committee meets monthly, the Physician Committee (which includes all other professions) meets monthly, and the Pharmacy Committee meets quarterly. As a result, weeks can pass before the participant is seen by URAP following a relapse or incident suggesting the possibility of a relapse.

URAP has developed an algorithmic relapse protocol called the URAP Score Sheet for Lapse/Relapse. While observing URAP meetings, two individuals had suffered a substance related relapse. In both cases the URAP Score Sheet for Lapse/Relapse was completed by the Director without the participation of the URAP Committee members. However, questions on the form such as the length of relapse, whether the individual drove while using, or whether the individual worked while using were not asked. These questions are critical in contributing to the score, the grand total of which results in the possibility of notification to the board and/or termination from the program. As a result, the severity of the relapse was not properly evaluated using the form and the grand total points were likely, or potentially, minimized. In addition, there was no discussion as to whether treatment efforts should be increased. A best practice response to a relapse of any kind typically involves asking the individual to withdraw from practice, receive a new assessment, follow through with the recommended treatment, and be evaluated for reintegration into practice. Should the individual refuse, he or she is reported to the Board.

Response to Relapse Behaviors

The PHP has, and consistently follows, a distinct policy regarding intensification of monitoring contact and therapeutic intervention when a participant is demonstrating signs worrisome for relapse; either by demonstrating behavioral irregularities while monitoring with the PHP, by demonstrating behavioral instability in the workplace, and/or by demonstrating avoidance of effective tissue or bodily fluid testing procedures and processes (i.e., missing call-ins for testing dates for urine drug tests or obfuscating testing collection procedures).

URAP's policy indicates that a variety of consequences may occur for "non-compliant diversionees" and lists those possible consequences, however there is no information as to how decisions for intensification of monitoring will be made. Instead, the policy indicates:

These are to be applied on a case by case basis, after consideration of the above mitigating circumstances, in a manner that is felt to represent the best change (sic) at recover (sic) for the individual, while guarding public safety, and not necessarily in any particular order.

There is also no clear definition of noncompliance. Missed call-ins appear to be handled inconsistently with some individuals being admonished and required to increase their meetings with URAP and others having no consequences at all. Furthermore, while there are requirements for the submission of reports, there is no policy as to the implementation of consequences when such reports are not submitted. As mentioned previously, data entry, as it pertains specifically to reports, is not easily found in Spectrum, and often is only found by reading the notes section of a participant's profile. In reviewing the files, it does not appear that any incidents of missed reports resulted in anything other than an admonishment to submit the appropriate paperwork. Many PHPs address this type of noncompliance with a tiered response. For example, the participant may first receive a verbal admonishment, then a written warning, and then be required to meet with an oversight committee or be referred to the board.

Adherence to Treatment Frequency Recommendations

The PHP has, and consistently follows a protocol for tracking participants' adherence to treatment frequency recommendations and for addressing deviations from treatment frequency recommendations.

URAP requires treatment providers provide a monthly report which documents progress in treatment. However, there is no protocol in place for addressing deviations from treatment recommendations or a lack of adherence. As a result, there appears to be a great deal of inconsistency as to how these issues are handled and frequently there is no action taken of any kind.

Processes for Dispute

The PHP has a process for a participant to pursue when the participant disagrees with the recommendations being made to him/her by the PHP staff.

URAP has no policy in place for handing any disagreement regarding recommendations. Amendments to the Diversion Agreement are often made at the request of the participant but there are no protocols for ensuring that any amendments are beneficial to the participant's recovery.

Timely Response to Participants Request for Intervention and Assistance

The PHP responds in a timely manner to requests for intervention and assistance.

No written policy exists. According to URAP staff, the typical requests for intervention and assistance fall into the category of obtaining clarification of items within the Diversion Agreement, providing notification of new events, or asking permission to substitute one type of required meeting for another; and are usually made via Spectrum. Compliance Specialists receive notification of an email and respond the same day. There is no documentation indicating that participants contact URAP to seek assistance for matters relating to their clinical care, which would warrant a response from an individual with an expertise in the treatment and management of substance use disorders.

Monitoring and Notification to Disciplinary Authority

The PHP demonstrates consistent identification of participants' commitment to health and wellness expectations as set forth in the PHP contracts/agreements with the individual participants and further demonstrates on-going intervention and support in accordance with state PHP protocols and state specific agreements with regulatory bodies or state laws. In assessing commitment to health and wellness expectations, the PHP adheres to a reasonable time frame to notify the disciplinary authority when such notification is required. Thus, confirmed notification efforts by PHPs will address public safety concerns by providing the opportunity for the regulatory bodies to be informed of the PHP response or intervention plan and allow the regulatory bodies to confirm that the plan is in the interest of patient safety while supporting professional health.

There exists a great deal of controversy regarding this standard. While URAP believes they communicate with DOPL in an appropriate and timely manner, DOPL employees strongly disagree. Many Bureau Managers and one Assistant Attorney General expressed concern that participants were allowed multiple relapses with little to no consequences. A review of the records indicate one participant began participating in URAP in May of 2015, and between November of 2015 and December of 2016 provided an abnormal test, a diluted test, an invalid test, a positive test, a missed test, and her employer expressed concern she was diverting Fentanyl. It appears clear that URAP did not respond adequately to relapse behaviors, placing both the individual and the public at risk. This is consistent with the 2016 Compliance Program Review which outlined many inconsistencies in the way URAP responded to relapses, including notifying DOPL.

There are two primary issues that make this guideline difficult to assess further. First, as noted above, participant records prior to 2016 simply cannot be relied upon and do not include information about relapses. Second, while we can review the records of participants who have

begun participation since 2016, we have observed that the URAP Score Sheet for Lapse/Relapse is not accurately or thoroughly completed and thus the severity score of the relapse is minimized (see above). As a result, the grand total score that is then entered into the record would not rise to the level indicative of a referral to the board. Unfortunately, we can only surmise that a minimization of the relapse score, be it intentional or due to a lack of thoroughness in using the instrument, results in a failure to inform DOPL of a participant's lack of commitment to wellness so that coordination can be made in the interest of patient safety while supporting professional health.

CONCLUSIONS AND RECOMMENDATIONS

Both URAP and DOPL are comprised of staff and volunteers who have dedicated time and energy toward helping professionals who struggle with substance use disorders. They should be applauded for their compassion and their service. Nonetheless, as this report shows, most of the best practices are not being adhered to. Many of the deficiencies can be corrected by developing policies and procedures and faithfully abiding by them. However, these policies and procedures must be consistent with FSPHP's guidelines. The Recommendation Report will provide detailed recommendations for explicit changes in the structure and operations of URAP. As a result, most of the recommendations that follow have been simplified.

Structure and Administrative Functions

1. The organizational structure of URAP should allow for effective and efficient management of all areas in which they offer services.
2. Any future structure of URAP should provide safe harbor to individuals voluntarily seeking services who are compliant.
3. To effectively monitor and manage professionals with substance use disorders, a baseline of expertise is necessary. Staff must have expertise consistent with their role in the program.
4. URAP should develop and follow a clear policy regarding avoiding and addressing financial, as well as other, conflicts of interest.
5. URAP should engage in education and outreach across the State. This includes education regarding the risks of substance misuse and abuse among the professions served, as well as various forms of education about the program to various audiences and organizations.
6. Once a model for restructuring URAP has been identified, DOPL should seek and include input from its staff, the professional organizations being served and other stakeholders. Once established, URAP should continue to cultivate these relationships. Close communication marked by transparency (while maintaining confidentiality and anonymity when appropriate) between DOPL and URAP will be essential in transitioning to a trusting relationship.

Data and Documentation

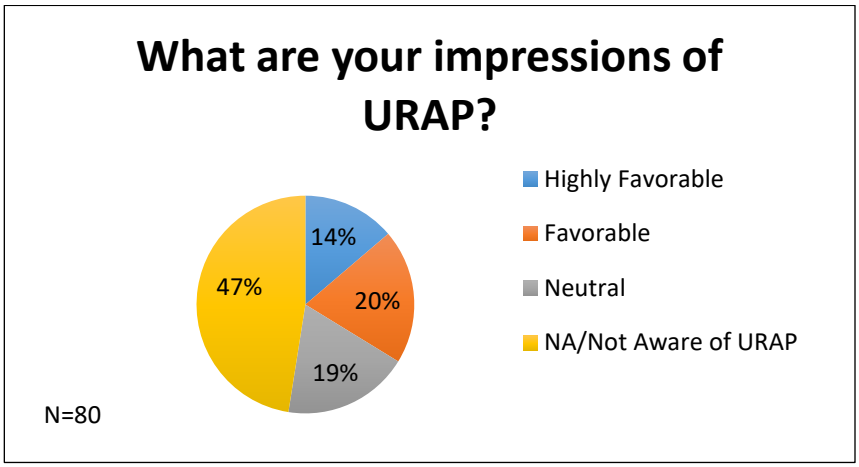
1. URAP should continue to utilize the data entry features of Spectrum, and should increase its usage of all available fields in order to maximize the accuracy of the data and the ability to evaluate the success of the Program. Additionally, URAP should implement a consistent procedure for the entry of required reports within Spectrum to ensure that participant requirements are accurately monitored.
2. URAP should develop a policy regarding the confidentiality of its records and any related communication, including privacy breaches. All records should be stored under double lock.
3. URAP should continue their procedures for documentation they have effectively developed.

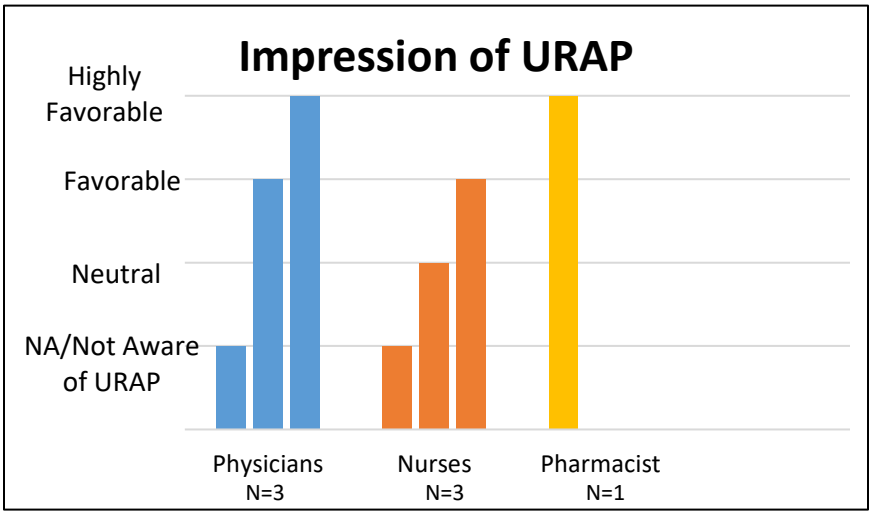
Procedural Elements

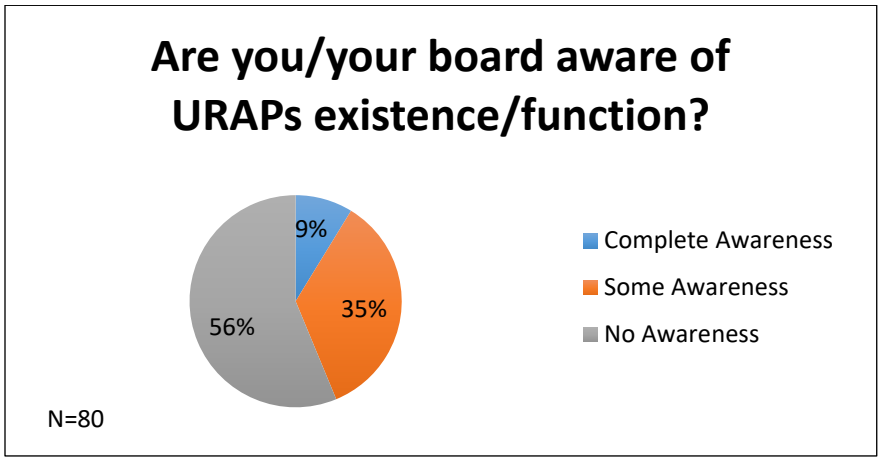
1. URAP should revise their current Diversion Agreement and add language where necessary to ensure that neither party needs to infer any requirements. URAP should also make clear who must be notified and agree, in writing, to any contractual requirement amendments. Finally, URAP should consider adding additional optional components (as listed previously) to their Diversion Agreement in order to continue to build a thorough monitoring agreement.
2. URAP should develop and establish consistent procedures for responding to individuals who contact them. Guidelines for the interview process and for the referral for assessment should be developed.
3. URAP should develop official policies regarding the length of monitoring and frequency of contact.
4. URAP should develop official policies regarding toxicology testing and evaluation.
5. URAP should develop a policy, and utilize it consistently, that outlines a graduated response to chemical relapse.
6. URAP should develop an official policy for therapeutic intervention when a participant is demonstrating signs worrisome for relapse.
7. URAP should develop and consistently follow a protocol for tracking participants' adherence to treatment frequency recommendations and for addressing deviations from treatment frequency recommendations.
8. URAP should develop a process for a participant to pursue when the participant disagrees with the recommendations being made to him or her by the URAP staff.
9. URAP should implement procedures for timely responses to requests for intervention and assistance that require the expertise of clinical staff.
10. URAP should adhere to a reasonable time frame to notify the disciplinary authority when such notification is required.

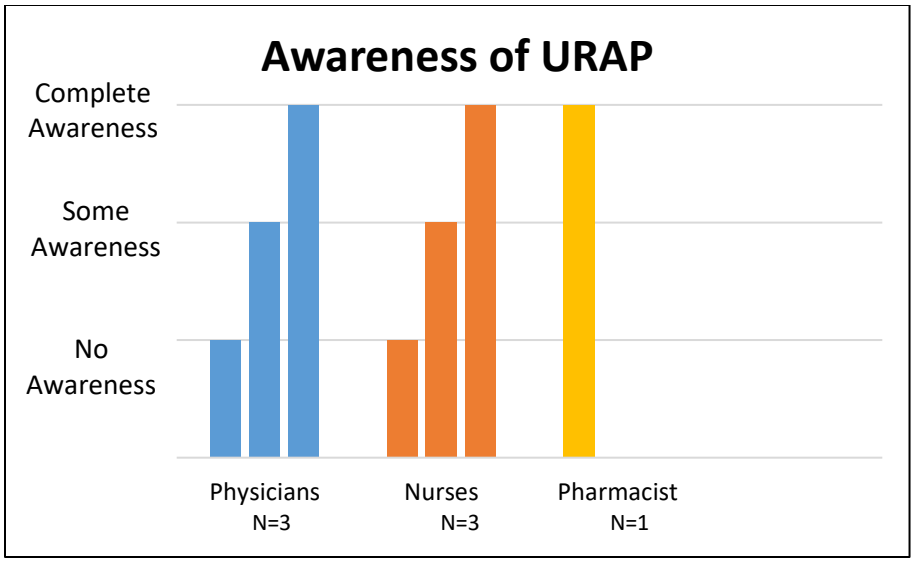
ATTACHMENT A

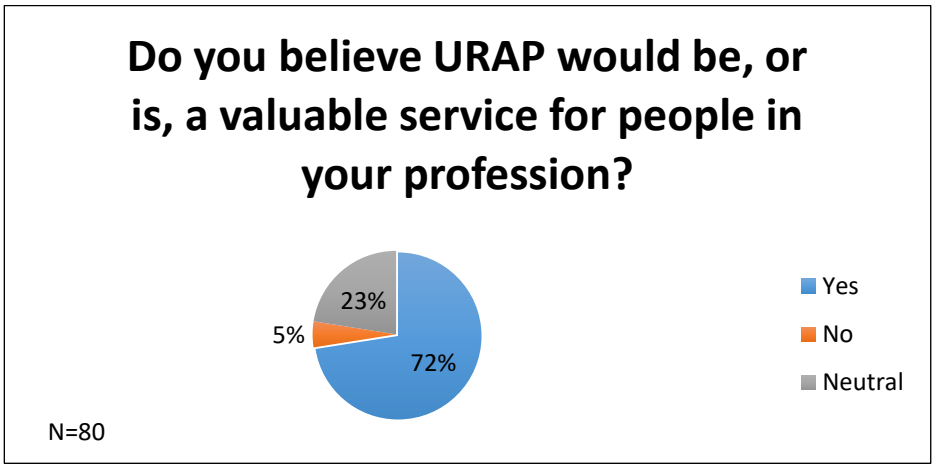
BOARD SURVEY

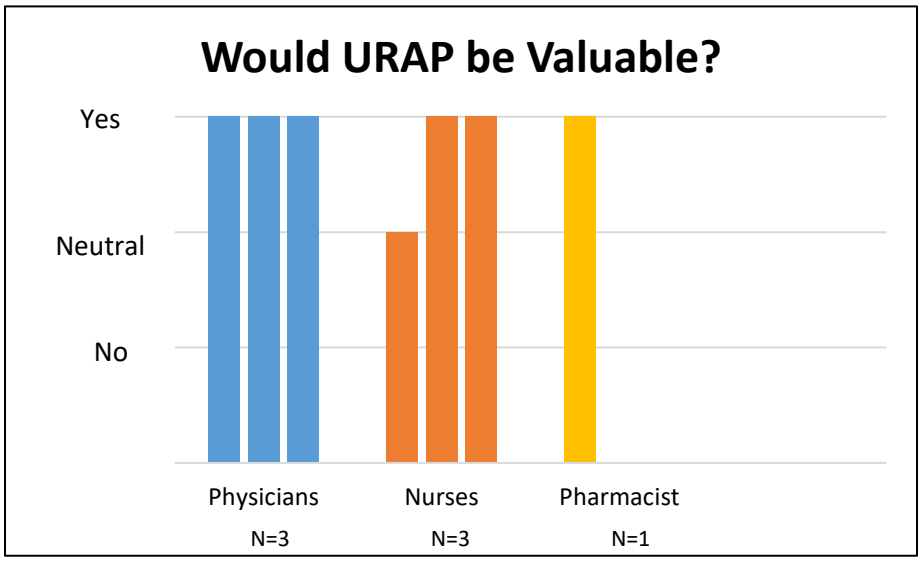







Awareness of URAP
Complete Awareness
Some Awareness
No Awareness
Physicians N=3
Nurses N=3
Pharmacist N=1


Do you believe URAP would be, or is, a valuable service for people in your profession?
23%
5%
72%
Yes
No
Neutral
N=80

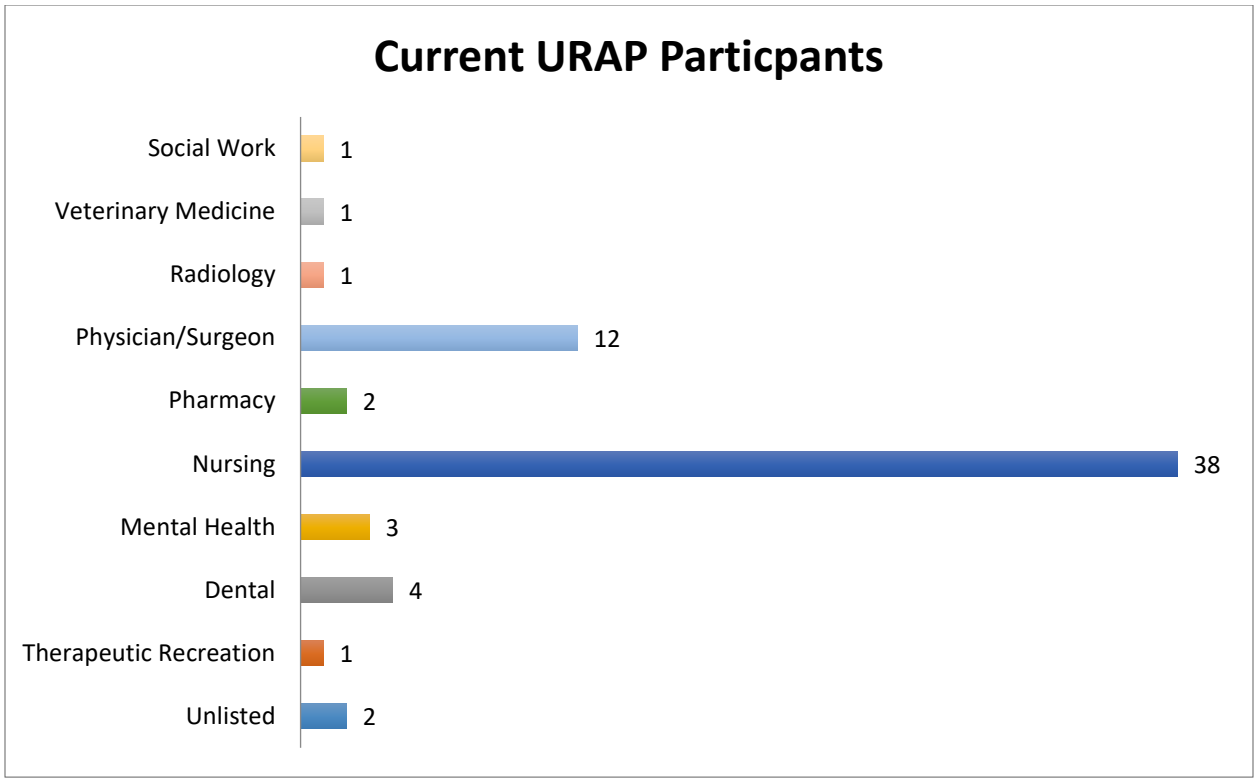


ATTACHMENT B

CURRENT URAP PARTICIPANTS

Professions of current URAP participants (as of this writing) is as follows:

- **1** Social Worker
- **1** Veterinarian
- **1** Radiologist
- **12** Physicians/Surgeons
- **2** Pharmacy Field: 2 pharmacists
- **38** Nursing Field: 6 APRN, 3 LPN, 29 RN
- **3** Mental Health Field: 1social services worker, 1 psychologist, 1 substance abuse counselor
- **4** Dental Field: 1 hygienist, and 3 dentists
- **1** Therapeutic Recreation Specialist
- **2** Unlisted



ATTACHMENT C

IN-PERSON SURVEYS WITH DOPL (N=11) AND URAP (N=8)

1. **URAP's policies and procedures are consistent with best practice models.**

   DOPL STAFF

   45% (5) Disagree
   45% (5) Neutral
   10% (1) Not enough knowledge to respond

   COMMITTEE MEMBERS

   12.5% (1) Neutral
   50% (4) Agree
   12.5% (1) Strongly Agree
   25% (2) Not enough knowledge to respond

2. **URAP's Director demonstrates awareness of best practice models and implements them accordingly.**

DOPL STAFF

27% (3) Strongly disagree
55% (6) Disagree
18% (2) Not enough knowledge to respond

COMMITTEE MEMBERS

25% (2) Neutral
25% (2) Agree
50% (4) Strongly Agree

3. **URAP's Committee members demonstrate awareness of best practice models and implements them accordingly.**

DOPL STAFF

9% (1) Strongly disagree
27% (3) Disagree
27% (3) Agree
37% (4) Not enough knowledge to respond

COMMITTEE MEMBERS

12.5% (1) Neutral
25% (2) Agree
50% (4) Strongly Agree
12.5% (1) Not enough knowledge to respond

4. **URAP's Director demonstrates knowledge of resources in the community.**

DOPL STAFF

9% (1) Strongly disagree
27% (3) Disagree
19% (2) Neutral
9% (1) Agree
36% (4) Not enough knowledge to respond

COMMITTEE MEMBERS

37.5% (3) Agree
62.5% (5) Strongly Agree

5. URAP's Committee members demonstrate knowledge of resources in the community.

DOPL STAFF

9% (1) Strongly disagree
27% (3) Disagree
9% (1) Neutral
9% (1) Agree
9% (1) Strongly agree
37% (4) Not enough knowledge to respond

COMMITTEE MEMBERS

12.5% (1) Neutral
75% (6) Agree
12.5% (1) Not enough knowledge to respond

6. URAP's organizational structure allows for continued improvement in serving the public.

DOPL STAFF

9% (1) Strongly disagree
37% (4) Disagree
9% (1) Neutral
37% (4) Agree
9% (1) Not enough knowledge to respond

COMMITTEE MEMBERS

12.5% (1) Disagree
12.5% (1) Neutral
25% (2) Agree
37.5% (3) Strongly Agree
12.5% (1) Not enough knowledge to respond

7. URAP promotes professional wellness in the community.

DOPL STAFF

18% (2) Strongly disagree
46% (5) Disagree
18% (2) Neutral
18% (2) Not enough knowledge to respond

COMMITTEE MEMBERS

25% (2) Disagree
12.5% (1) Neutral
12.5% (1) Strongly Agree
50% (4) Not enough knowledge to respond

8. URAP has exceptional relationships with professional organizations.

DOPL STAFF

18% (2) Strongly disagree
46% (5) Disagree
18% (2) Neutral
18% (2) Not enough knowledge to respond

COMMITTEE MEMBERS

25% (2) Neutral
12.5% (1) Agree
25% (2) Strongly Agree
37.5% (3) Not enough knowledge to respond